# Jan Tkachuk, M.A., RP

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## CLIENT INTAKE AND INFORMED CONSENT FORM

When you begin therapy, it is important for you to fill out a client intake and informed consent form. The first purpose of this form is to collect general personal and contact information, including how you prefer to be contacted while you are in therapy. The second purpose is to outline the important aspects of your psychotherapy agreement with me including policies, confidentiality and other information that provide you with *informed consent*.

I encourage you to ask any questions about this form and psychotherapy in general *before* your first session to ensure that starting therapy with me is right for you at this time. You may also have questions that arise during therapy. Please bring them to my attention at the time to ensure that our work together best meets your needs.

Please read through and fill out the following form.

Full Name: ___________________________________________________________

Address (including postal code): __________________________________________

Date and Place of Birth: _________________________________________________

Current Occupation/Schooling: ___________________________________________

Cell/Text: ___________________________ Can messages be left on voicemail/text? YES__NO__

Home Phone: ________________________ Can messages be left at your home number? YES__NO__

Business Phone: _____________________ Can messages be left at your work number? YES__NO__

Email address: ___________________________________________ Is it confidential? YES__NO__

Referral Source: _____________________ Emergency Contact(s): _____________________

Relation to you: ______________________ Phone to reach them: _____________________

## INFORMED CONSENT

As a registered psychotherapist, I am a member of the College of Registered Psychotherapists of Ontario (CRPO) and I adhere to the code of conduct and standards set out by this regulatory body.

### ***CONFIDENTIALITY***

I understand that all information shared with Jan Tkachuk will be kept confidential with the following possible exceptions:

1. If Jan is subpoenaed to provide documentation or to testify, I understand that she is required by law to do so.
2. I understand that Jan may consult with my other health professionals when such consultation may prove to be helpful to my therapy. My consent will be required and nothing other than information relevant and pertaining to my presenting concerns will be discussed.
3. If I report information of current or ongoing child abuse, I understand that Jan is required by law to report this information to the Children's Aid Society.
4. If I give information to Jan that suggests I am an imminent danger to myself or to others, I understand that she is required to communicate this information to the police in order to ensure my safety and/or the safety of others.

In the case of child abuse or imminent danger, I understand that Jan will encourage me to communicate this information to the appropriate authorities myself to protect my confidentiality.

### ***WHAT YOU CAN EXPECT FROM YOUR THERAPY***

Sessions are generally 1 hour in length. You may want to book a longer session in advance or to request some extra time at the end of a session. When possible, longer sessions are booked and billed in 15 minute increments after the initial hour.

There are no standard, required or optimal times between sessions. The number and frequency of your sessions will vary according to your needs at the time, your schedule and my availability. I encourage you to discuss any change to your therapy needs as you become aware of them. We can then discuss what options are available to you.

### ***FEE FOR SERVICES AND PAYMENT***

**Standard fee for service:** $135 per hour plus HST (13% = 17.55) for a total of $152.55/hr.
**Payment of the fee is due, in full, at the start of your session.*

**Payment options include:** cash, e-transfer or cheque. If you require a receipt please request one.
**Reimbursements through benefits and payments by third parties:** Sometimes your fees for service are fully or partially covered by work/school benefits, an insurance company or by someone other than you (such as a family member). Please note that payment prior to your psychotherapy session remains your responsibility. I will provide you with a receipt so that you may be reimbursed by your other funding sources.

Please note that outside funding does NOT permit anyone to know anything about your therapy sessions. If you wish me to share any information, you will need to provide written permission.

During your therapy, you may require me to prepare a report, documentation or consult with a third party. You will be billed for these services at my standard hourly rate. I will give you an estimated length of the time and costs involved. We will determine what information about you is disclosed and what your financial responsibilities are for these additional services.

## *CANCELLATION POLICY*

Please note that you will be required to pay for any session you miss if I have not received at least 24 hours notice. Your appointment time is specifically reserved for you and 24 hour notice of any change or cancellation is required in order to fill that open spot and to find an alternative day and time for you.

To prevent having to pay cancellation fees, I encourage you to anticipate the weather, travel and other circumstances which may impact your ability to attend your session or provide sufficient notice.

**I have read, understand and agree to the above policies.**

Date__________________________ Client #1 Signature______________________________

Date__________________________ Client #2 Signature______________________________

Date__________________________ Guardian Signature______________________________

Date______________________ Therapist Signature______________________________